Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

980 Ninth Street, Suite 500
Sacramento, CA 95814
916-323-0435 voice
916-323-0438 fax

February 7, 2005

Douglas Schur
Vice President, Deputy General Counsel
Blue Cross of California
1 Wellpoint Way
Thousand Oaks, CA 91362

RE: Blue Cross of California
DMHC Complaint Number 96935
Enforcement Matter Number 03-329
Health Plan Implementation of Independent Medical Review (IMR)

Dear Mr. Schur:

LETTER OF AGREEMENT

The Department of Managed Health Care (hereinafter "the Department") has concluded its investigation of Blue Cross of California (hereinafter "Blue Cross" or the "Plan") in the above referenced matter. The Department investigated the failure of Blue Cross to comply with California Health and Safety Code section 1374.34 regarding implementation of an Independent Medical Review (IMR) decision that overturned the Plan's denial of coverage.

This Letter of Agreement sets forth the Department's interpretation of the requirements of California Health and Safety Code section 1374.34 as applied to the facts of this case. A Plan's failure to properly implement an IMR decision can constitute a major violation of the Knox-Keene Health Care Service Plan Act of 1975.

The health care service in question included inpatient and/or residential psychiatric care for which the duration was not specified, either by the order of the patient's physician or the IMR reviewer. After the IMR decision that required the Plan to cover the service, the Plan

authorized coverage for a few days while it also conducted its concurrent review. After allowing approximately five days of additional coverage after the Department adopted the IMR decision, the Plan again terminated coverage, ostensibly based on its concurrent review. However, at the time the Plan issued that termination of coverage, it had not acquired any new information about the patient's medical condition that reasonably supported the view that, since the IMR determination, the service had become no longer medically necessary.

During the case in question, the Department's Help Center was already actively involved due to the enrollee's complaint. Although the Plan had re-asserted its denial of coverage, it appears that the Plan, in compliance with the Department's intervening direction, nonetheless continued coverage until the enrollee's maximum contractual benefit for that service had been provided.

The Department also notes the Plan's assertion that, before it re-asserted its denial, it requested but was unable to obtain updated medical information from the provider. However, the Department was unable to conclude that the provider and enrollee had willfully withheld medical information or that the Plan had reasonably exhausted its opportunities and means to obtain additional medical information over a reasonable amount of time before re-asserting its denial of coverage.

The Department has evaluated the requirements of section 1374.34 as it applies to the facts of this case and concluded that the Plan's denial of coverage after the IMR decision was in violation of section 1374.34. For the facts at hand, the Department has concluded that section 1374.34 applies in the following manner:

> The requirements imposed on health plans by the Independent Medical Review (IMR) implementation statute (California Health and Safety Code section 1374.34) include that, when a health care service has been found by Independent Medical Review (IMR) to be medically necessary for a particular patient, and that service, either by standard medical practice or existing order of a treating physician or the decision of the IMR Review Organization, expressly or implicitly, is meant to be a continuing service of an unspecified duration in the absence of a change in the patient's condition, then that patient's health plan (and/or that plan's capitated provider or other delegated payor) is required to provide the service and/or coverage for it at least until either: (1) the service is stopped or materially changed pursuant to order of the medical providers who are in charge of the patient's care; (2) the plan's medical director or other licensed physician with authority to review authorization or utilization decisions for the subject enrollee acquires and considers new information about the patient's medical condition and/or health status that reasonably supports a

determination that the subject health care service has, since the IMR decision, become no longer medically necessary for that patient; or (3) the enrollee's coverage benefits for that service are otherwise exhausted pursuant to quantitative limits in the terms of coverage.

The Plan hereby confirms its agreement that it will implement IMR decisions in a manner consistent with the requirements discussed above, and will amend its related procedures, policies and practices accordingly.

Sincerely,

Amy L. Dobberteen
Assistant Deputy Director

SJB:vb

Accepted and Agreed by Blue Cross of California

Dated: 2/23/05

Douglas Schur
Vice President, Deputy General Counsel
Blue Cross of California